DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 4 3

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2000-2001 $ _____
b. FFY 2001-2002 $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A page 10
Attachment 3.1A Supplement 3e
Attachment 3.1B Page 9
Attachment 3.1B Supplement Page 3e
Attachment 4.19-B page 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A Page 10
Attachment 3.1-B Page 9
No Previous Pages: Attachment 3.1-A
Attachment 3.1-B Supplement 3e
Attachment 4.19-B page 16

10. SUBJECT OF AMENDMENT:
Primary Care Case Management

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

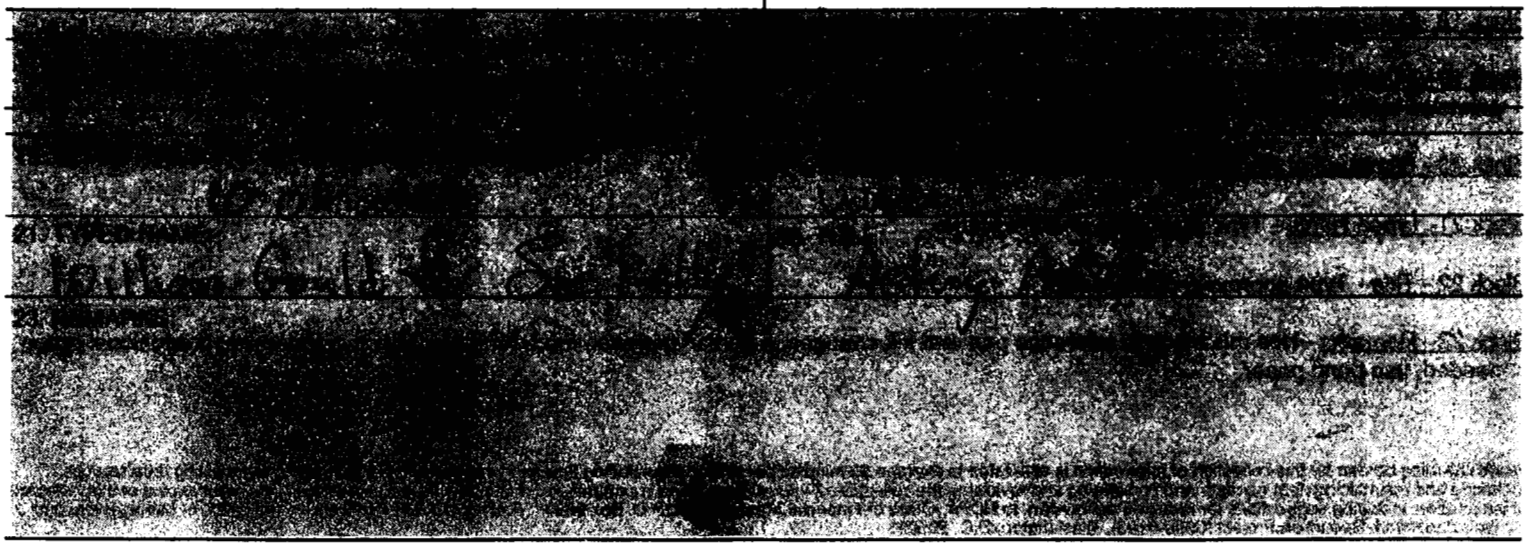
12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Antonia C. Novello, M.D., M.P.H., Dr.P.H.

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 28, 2000

16. RETURN TO:



FORM HCFA-179 (07-92)

Instructions on Back

State: New York

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

____ Provided __X__ Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

__X__ Provided: __ State Approved (Not Physician) Service Plan Allowed

__X Services Outside the Home Also Allowed

__X Limitations Described on Attachment

___ Not Provided

27. Primary Care Case Management

__X__ Provided ___ Not Provided

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27. The State elects to provide medical assistance services to eligible individuals through a Primary Care Case Management Program. PCCMs are responsible for locating, coordinating, and monitoring covered primary care to all individuals enrolled with a case manager.

PCCM providers may be physicians, physician group practices, entities employing or having other arrangements with physicians to provide PCCM Services under the contract. Nurse practitioners may also be a PCCM provider.

A PCCM will provide for arrangements with, or referrals to a sufficient number of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care.

PCCMs are required to be accessible 24 hours/seven days per week to provide information, referral and treatment to enrollees. PCCMs may not restrict an enrollees access to emergency services, or require prior authorization of emergency services.

A PCCM shall be geographically accessible to enrollees. Primary care providers must meet State standards for travel time and distance.

TN 00-43 Approval Date MAR 28 2001
Supersedes TN _____ Effective Date OCT 0 1 2000

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State: New York

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

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__X Services Outside the Home Also Allowed

__X Limitations Described on Attachment

___ Not Provided

26. Primary Care Case Management

__X__ Provided ___ Not Provided

TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Primary Care Case Management	PCCMs may be reimbursed on a capitated or fee-for-service basis and may be paid case management fees. If capitated, the capitation will cover primary care services routinely provided in a primary care practitioner's office.